

Health Priority: Access to Primary and Preventive Health Services
Objective 4: Access to Oral Health Services

Long Term (2010) Subcommittee Outcome Objective: By 2010, increase by 10 percentage points the proportion of each of the following populations who receive ongoing preventive and restorative oral health care: Medicaid/BadgerCare, uninsured and underinsured populations.

Inputs	Outputs		Outcomes		
	Activities	Participation/ Reach	Short-term 2002-2004	Medium-term 2005-2007	Long-term 2008-2010
<ul style="list-style-type: none"> ▪ Individuals with oral disease ▪ Families with members with oral disease ▪ Leaders ▪ Coalitions ▪ Public health system partners ▪ Health care providers ▪ Oral health care providers ▪ Benefits managers ▪ Political leaders ▪ State government agencies ▪ Cultural leaders 	<p>Obtain baseline data.</p> <p>Expand the use of evidence-based outreach and education programs to underserved groups.</p> <p>Establish oral health start-up/expansion grants to increase the capacity of community and school-based clinics to serve high risk populations.</p> <p>Initiate new and innovative care models using dental hygienists, assistants, and other health professionals.</p> <p>Create a more flexible licensure policy to encourage dentists to practice in the state.</p> <p>Identify a benchmark plan for minimum services for health insurance coverage that includes dental.</p> <p>Increase payment rates for Medical Assistance covered dental services.</p>	<p><u>Parents/Families:</u> Education program regarding importance of oral health and advocacy for increased programming</p> <p><u>High risk populations:</u> Targeting of limited resources to high risk populations</p> <p><u>Individuals with oral disease:</u> Education and advocacy efforts</p> <p><u>Faith communities:</u> Advocacy for increased programming for at risk populations</p> <p><u>Businesses:</u> Education and advocacy for prevention programs that reduce insurance and treatment costs</p> <p><u>Primary health care:</u> Incorporate oral health into primary care.</p>	<p>By 2001, question(s) will be added to ongoing Wisconsin Family Health Survey and data needs specific to this objective will be incorporated into Wisconsin Youth Oral Health Data Collection Plan.</p> <p>By 2002, funding for community water fluoridation will be increased by 100 percent.</p> <p>By 2002, requests for new dental Health Professional Shortage Area designations will receive a state response within eight weeks.</p> <p>By 2003, all counties likely to be eligible for dental Health Professional Shortage Areas will be identified and analyzed. Requests for federal designation will be submitted for those that meet the Federal designation criteria.</p>	<p>By 2005, payment rates will be increased to 75 percent of median charges in Medical Assistance program.</p> <p>By 2005, bonus payments will be established for dental Medical Assistance providers based on the volume of unduplicated recipients served in dental Health Professional Shortage Areas.</p> <p>By 2005, number of patients served in each type of preventive program will be increased by 25 percent.</p> <p>By 2005, funding for community water fluoridation will be increased by 200 percent from baseline.</p> <p>By 2006, 10 additional dental preventive programs (includes dental sealant, fluoride mouthrinse, fluoride supplement, and</p>	<p>By 2010, payment rates at 85 percent of median charges will be established in Medical Assistance programs.</p> <p>By 2010, bonus payment of 30 percent will be available to volume providers.</p> <p>By 2010, the population on central water supplies receiving fluoride will increase by 4 percent from baseline.</p>

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	Activities	Participation/ Reach	Short-term 2002-2004	Medium-term 2005-2007	Long-term 2008-2010
<ul style="list-style-type: none"> ▪ Faith community leaders ▪ Schools and educators ▪ Educators in health profession institutions ▪ Public policy makers ▪ Training ▪ Funding ▪ Media ▪ Educational materials 	<p>Establish bonus dental Medical Assistance payments based on the volume of unduplicated recipients served in dental Health Professional Shortage Areas.</p> <p>Provide preventive care including dental sealants, fluoride mouth-rinsing, fluoride supplements, and fluoride varnish programs.</p> <p>Provide additional funding for community water fluoridation.</p> <p>Develop a core preventive oral health curriculum for primary care health professionals including competencies in infant oral care, management of high-risk children, oral health assessments by primary care providers, and interprofessional coordination.</p> <p>Strengthen public oral health infrastructure to support community level prevention programs through region-based Division of Public Health dental hygienists.</p>	<p><u>Policymakers</u>: Pass legislation for increased resources and change in dental practice statutes</p> <p><u>Professional groups</u>: Support and advocacy for increased programming and changes in scope of practice</p> <p><u>School professionals/ school boards/teacher organizations</u>: Support and advocacy for increased school-based programming</p>	<p>By 2003, regulatory authorizations will be in place to allow implementation of new and innovative care models using dental hygienists, assistants, and other health professionals.</p> <p>By 2004, an evidence-based outreach and education program will be developed for underserved populations.</p> <p>By 2004, oral health start-up/expansion grants will be established to increase the capacity (facilities, equipment, providers) of community and school-based clinics to serve high risk populations (e.g., youth, long-term care, the disabled).</p> <p>By 2004, regulatory authorizations will be in place for a more flexible dental licensure policy to encourage additional dentists to practice in the state.</p> <p>By 2004, the number of oral</p>	<p>fluoride varnish programs) will be in operation.</p> <p>By 2006, 10 additional clinical treatment programs will be in operation.</p>	

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	Activities	Participation/ Reach	Short-term 2002-2004	Medium-term 2005-2007	Long-term 2008-2010
	<p>Increase the number of oral health professionals and resources in low income communities through incentive program strategies including: service-learning sites, loan repayment, low-interest loans for infrastructure, Medical Assistance reimbursement increases, tax credits, more flexible licensure policy to facilitate increased mobility of dentists to the state and reducing the administrative burden of Medical Assistance.</p> <p>Increase the racial and ethnic diversity of dental professionals through recruitment, retention, and mentor programs.</p>		<p>health professionals who serve high-risk, underserved communities will be increased.</p> <p>By 2004, a benchmark plan for minimum services for health insurance coverage, including dental, will be identified.</p> <p>By 2004, selected oral health prevention services will be included as Medical Assistance billable services for primary care providers within their scope of practice.</p> <p><u>Workforce Linkage:</u></p> <p>By 2003, develop a core preventive oral health curriculum for primary care health professionals, including competencies in infant oral care, management of high-risk children, oral health assessments by primary care providers, and interprofessional coordination.</p> <p>By 2004, implement core preventive oral health curriculums in medical and nursing schools.</p>	<p><u>Workforce Linkage:</u></p> <p>By 2005, strengthen public oral health infrastructure to support community level prevention programs through the employment of region-based Division of Public Health dental hygienists.</p> <p>By 2006, increase the number of oral health professionals and resources in low-income communities through incentive program strategies.</p>	<p><u>Workforce Linkage:</u></p> <p>By 2010, graduates from dental and dental hygiene training programs will more closely reflect the cultural diversity of the state population (e.g., rural, racial/ethnic).</p> <p>By 2010, an increased percentage of dental and hygiene school graduates will report plans to work in dental Health Professional Shortage Areas.</p> <p>By 2010, an increased percentage of graduates from dental and dental hygiene training programs will have had learning experiences in underserved practice settings.</p>

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Objective 4: Access to Oral Health Services

Long-term (2010) Subcommittee Outcome Objective:

By 2010, increase by 10 percent the proportion of each of the following populations who receive ongoing preventive and restorative oral health care: Medicaid/BadgerCare, uninsured, and underinsured populations.

- Working Objective: By 2010, increase by 10 percent the proportion of each of the following populations who saw an oral health provider in the past year: Medicaid/BadgerCare, uninsured all year, and insured part of the year.

Wisconsin Baseline	Wisconsin Sources and Year
22.5 percent of Medical Assistance/BadgerCare eligibles received any dental care in 2001 in Wisconsin.	Department of Health and Family Services, Division of Health Care Financing. <i>Medicaid/BadgerCare Claims</i> . (2001).
36 percent of the uninsured reported a dentist visit in the past year.	Department of Health and Family Services, <i>Family Health Survey</i> . (2000).
60 percent of those with insurance for part of the year reported a dentist visit in the past year.	Department of Health and Family Services Family Health Survey. <i>Family Health Survey</i> . (2000)

Federal/National Baseline	Federal/National Sources and Year
20 percent of children and adolescents under age 19 years at or below 200 percent of the Federal poverty level received any preventive dental service in 1996.	Medical Expenditure Panel Survey (MEPS), Agency for Healthcare Research and Quality (1996)

Related USDHHS Healthy People 2010 Objectives			
Chapter	Goal	Objective Number	Objective Statement
21 – Oral Health	Prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services.	21-8	Increase the proportion of children who have received dental sealants on their molar teeth.
		21-10	Increase to 56 percent the proportion of children and adults who use the oral health system each year.
		21-11	Increase to 25 percent the proportion of long-term care residents who use the oral health care system each year.
		21-12	Increase to 57 percent the proportion of low-income children and adolescents who received any preventive dental service in the past year.

Definitions	
Term	Definition
Dental caries/dental decay/tooth decay/cavities	An infectious disease that results in the loss of minerals on the tooth surface.
Sealants/dental sealants	Plastic coatings applied to the surfaces of teeth (primarily chewing surfaces) to protect the tooth surfaces from collecting food, debris, and bacteria that promote the development of dental decay.
Preventive dentistry	The procedures in dental practice and health programs that prevent the occurrence of oral diseases.
Preventive care	Employs techniques and agents to avoid the onset of disease, to reverse the progress of the initial stages of disease, or to arrest the disease process before treatment becomes necessary.
Restorative care (secondary and tertiary prevention)	Employs routine treatment methods to stop a disease process and to restore tissues to as near normal as possible. Restorative care also includes measures necessary to replace lost tissues and to rehabilitate patients to the point that function is as near normal as possible after the failure of secondary prevention.
Oral health providers	Includes dentists and dental hygienists. Collaborating team members include but are not limited to: dental assistants, primary care providers, health educators, nurses, nutritionists, social workers, allied health workers, and other community outreach workers.

Rationale:

- Basic insurance/health plans should include a defined set of primary and preventive physical, mental, and oral health care services.
- The terms "uninsured" and "underinsured" describe inadequate insurance coverage for oral health services.
- Oral health is an essential and integral component of health throughout life.
- Oral health includes much more than healthy teeth and gums (e.g., being free of chronic oral-facial pain conditions, oral and pharyngeal cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the craniofacial complex)
- Poor oral health and untreated oral diseases and conditions can have a significant negative impact on quality of life. Left untreated, the pain and infection caused by tooth decay can lead to problems in eating, speaking, and learning.
- Dental caries (tooth decay) is the single most common chronic disease of childhood.
- Dental caries is an infectious, transmissible disease in which bacterial byproducts (i.e., acids) dissolve the hard surfaces of teeth. The major source of the infection is thought to be via the primary caregiver.
- Safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease. These measures include daily oral hygiene procedures and other lifestyle behaviors; community programs such as community water fluoridation and tobacco cessation programs; and provider-based interventions such as oral prophylaxis, the placement of dental sealants, and examinations.
- There are profound and consequential oral health disparities within Wisconsin's population. Although there have been gains in oral health status for the population as a whole, they have not been evenly distributed across subpopulations. African Americans, Hispanics, and Native Americans generally have the poorest oral health of any racial and ethnic groups.

- Barriers to care include cost, lack of or inadequate dental insurance, discrimination, culture, fear, service capacity, knowledge, and inadequate workforce.

Outcomes:

Short-term Outcome Objectives (2002-2004)

- By 2001, question(s) will be added to ongoing Wisconsin Family Health Survey and data needs specific to this objective will be incorporated into Wisconsin Youth Oral Health Data Collection Plan.
- By 2002, funding for community water fluoridation will be increased by 100 percent.
- By 2002, requests for new dental Health Professional Shortage Area designations will receive a state response within eight weeks.
- By 2003, all counties likely to be eligible for dental Health Professional Shortage Areas will be identified and analyzed. Requests for federal designation will be submitted for those that meet the Federal designation criteria.
- By 2003, regulatory authorizations will be in place to allow implementation of new and innovative care models using dental hygienists, assistants, and other health professionals.
- By 2004, an evidence-based outreach and education program will be developed for underserved populations.
- By 2004, oral health start-up/expansion grants will be established to increase the capacity (facilities, equipment, providers) of community and school-based clinics to serve high risk populations (e.g., youth, long-term care, and the disabled).
- By 2004, regulatory authorizations will be in place for a more flexible dental licensure policy to encourage additional dentists to practice in the state.
- By 2004, the number of oral health professionals who serve high-risk, underserved communities will be increased by expanding the legal scope of practice of dental hygienists and expanding the legal delegation of dental care.
- By 2004, a benchmark plan for minimum services for health insurance coverage, including dental, will be identified.
- By 2004, selected oral health prevention services will be included as Medical Assistance billable services for primary care providers within their scope of practice.

Medium-term Outcome Objectives (2005-2007)

- By 2005, payment rates will be increased to 75 percent of median charges in Medical Assistance program.
- By 2005, bonus payments will be established for dental Medical Assistance providers based on the volume of unduplicated recipients served in dental Health Professional Shortage Areas.

- By 2005, number of patients served in each type of preventive program will be increased by 25 percent.
- By 2005, funding for community water fluoridation will be increased by 200 percent from baseline.
- By 2006, 10 additional dental preventive programs (includes dental sealant, fluoride mouthrinse, fluoride supplement, and fluoride varnish programs) will be in operation.
- By 2006, 10 additional clinical treatment programs will be in operation.

Long-term Outcome Objectives (2008-2010)

- By 2010, payment rates at 85 percent of median charges in Medical Assistance program will be established.
- By 2010, bonus payment of 30 percent will be available to volume providers.
- By 2010, the population on central water supplies receiving fluoride will increase by 4 percent from baseline.

Inputs: (*What we invest – staff, volunteers, time money, technology, equipment, etc.*)

- Individuals with oral disease: This effort will require advocacy by consumers.
- Families: Families with individuals with oral disease must advocate for change.
- Leadership: Policy makers, community leaders, government agencies, professional health organizations must provide appropriate leadership.
- Coalitions: Both public and private groups must come together to work on improving the oral health status of Wisconsin residents.
- Service Delivery: Division of Health Care Financing, Division of Public Health, Department of Regulation and Licensing, Department of Public Instruction, Wisconsin Technical College System, Marquette University School of Dentistry, Medical College of Wisconsin, Wisconsin Primary Health Care Association, University of Wisconsin, schools of nursing, public and private colleges and universities, Area Health Education Centers, Wisconsin Dental Examining Board, Wisconsin Dental Association, Centers for Disease Control and Prevention, Association of State and Territorial Dental Directors, local public health departments, the legislature, professional health care organizations, Office of the Commissioner of Insurance, and the insurance industry.
- Legislative change: Specific to Medical assistance reimbursement, licensure, scope of practice, and prevention programs.
- Funding: Increased funding required for Medical Assistance program, primary care clinics, and prevention programs.
- Licensure and Public Policy: Division of Health Care Financing, Division of Public Health, Wisconsin Dental Association, legislators, insurance companies, and the Department of Regulation and Licensing.
- Data Capacity: Public Health System Partners, Division of Health Care Financing, Division of Public Health, Office of the Commissioner of Insurance, public health system partners, and the Legislature.

- Outreach/Education: Division of Health Care Financing, Division of Public Health, Department of Public Instruction, local public health departments, and community-based organizations.
 - Resources
 - Medical assistance outreach/ Temporary Assistance for Needy Families
 - Funding
- Payment: Division of Health Care Financing, Legislature, Office of the Commissioner of Insurance, and the insurance industry.
 - Legislative change
 - Resources
 - Funding

Outputs: *(What we do—workshops, meetings, product development, training. Who we reach—community residents, agencies, organizations, elected officials, policy leaders, etc.)*

Activities:

- Establish oral health start-up/expansion grants to increase the capacity (facilities, equipment, providers) of community and school-based clinics to serve high risk populations (e.g., youth, long-term care, disabled): Award start-up grants to organizations that demonstrate the ability to provide dental services effectively to Medical Assistance patients and the uninsured; award start-up grants to eligible community and school-based clinics to support their capacity to serve low income populations; award start-up grants to eligible health care entities to provide care to residents of long-term care facilities.
- Initiate new and innovative care models using dental hygienists, assistants, and other health professionals: Include distance technology to facilitate oral diagnosis and prescription of services, early childhood caries prevention and health promotion training, perinatal screening and education programs, and oral health community assessments.
- Increase payment rates for Medical Assistance covered dental services.
- Create a more flexible licensure policy to encourage dentists to practice in the state:
 - Licensure of foreign trained dentists – allow graduates of dental colleges in other countries to take the examination and to be licensed as either a dentist or a dental hygienist.
 - Licensure of U.S. trained dentists – allow license reciprocity for dentists and dental hygienists licensed in other states as long as there are no license restrictions or sanctions.
- Increase the number of oral health professionals that serve high-risk, underserved communities:
 - Expand the dental hygienist scope of practice as defined in statute to permit performing specified duties without prescription.
 - Expand duties allowed under delegation for dental assistants and registered dental hygienists.
 - Increase capacity to designate dental Health Professional Shortage Areas.
 - Reimburse retired dentists the cost of license fee and malpractice insurance in exchange for the dentist's provision of dental services at a community dental clinic.

- Award start-up grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals; award teaching grants.
- Identify a benchmark plan for minimum services for health insurance coverage that includes dental:
 - Consider Federally mandated and optional services.
 - Consider BadgerCare levels.
 - Build on findings from Division of Health Care Financing/ Health Resources and Services Administration State Planning Grant.
 - Create/compile data on current levels of coverage by type of plan.
 - Identify gaps between existent plans and benchmark plan.
 - Determine priorities and fiscal note for closing identified gaps.
- Add selected oral health prevention services as Medical Assistance billable services for primary care providers within their scope of practice.
- Establish bonus dental Medical Assistance payments based on the volume of unduplicated recipients served in dental Health Professional Shortage Areas.
- Provide preventive care (includes dental sealant, fluoride mouthrinse, fluoride supplement, and fluoride varnish programs).
- Expand the use of evidence-based outreach and education programs to underserved groups: Provide education on oral health basics. This activity will expand and establish a continuum of care engaging medical and dental providers to provide outreach, prevention, and early intervention oral health services.
- Provide additional funding for community water fluoridation (community-based preventive service).
- Obtain baseline data for objective: Department of Health and Family Services will add question(s) to the Family Health Survey to measure objective related to insurance coverage. Incorporate baseline data needs for this objective into Wisconsin Youth Oral Health Data Collection Plan.

Participation/Reach

- Parents/Families: Education program regarding importance of oral health and advocacy for increased programming.
- High risk populations: Targeting of limited resources to high risk populations.
- Individuals with oral disease: Education and advocacy efforts.
- Faith communities: Advocacy for increased programming for at risk populations.
- Businesses: Education and advocacy for prevention programs that reduce insurance and treatment costs.
- Primary health care: Incorporation of oral health into primary care.
- Policymakers: Passage of legislation for increased resources and change in dental practice statutes.

- Professional groups: Support and advocacy for increased programming and changes in scope of practice.
- School professionals/school boards/teacher organizations: Support and advocacy for increased school-based programming.

Workforce Linkages and Outcome Objectives Identified

Short-term Outcome Objectives (2002-2004)

- By 2003, develop a core preventive oral health curriculum for primary care health professionals including competencies in infant oral care, management of high-risk children, oral health assessments by primary care providers and interprofessional coordination.
- By 2004, implement core preventive oral health curriculums in medical and nursing schools.

Medium-term Outcome Objectives (2005-2007)

- By 2005, strengthen public oral health infrastructure to support community level prevention programs through the employment of region based Division of Public Health dental hygienists.
- By 2006, increase the number of oral health professionals and resources in low-income communities through incentive program strategies.

Long-term Outcome Objectives (2008-2010)

- By 2010, graduates from dental and dental hygiene training programs will more closely reflect the cultural diversity of the state population (e.g., rural, racial/ethnic).
- By 2010, an increased percentage of dental and hygiene school graduates will report plans to work in dental Health Professional Shortage Areas.
- By 2010, an increased percentage of graduates from dental and dental hygiene training programs will have had learning experiences in underserved practice settings.

Inputs: *(What we invest--staff, volunteers, time money, technology, equipment, etc.)*

- Division of Health Care Financing, Division of Public Health, Department of Regulation and Licensing, Department of Public Instruction.
- Wisconsin Technical College System, Marquette University School of Dentistry, Medical College of Wisconsin, University of Wisconsin, schools of nursing, public and private colleges and universities.
- Area Health Education Centers
- Professional health care organizations
- Local public health departments
- Legislature
- Public and private partners

Outputs: *(What we do--workshops, meetings, product development, training. Who we reach--community residents, agencies, organizations, elected officials, policy leaders, etc.)*

Activities:

- Develop a core preventive oral health curriculum for primary care health professionals including competencies in infant oral care, management of high-risk children, oral health assessments by primary care providers and interprofessional coordination. This should be taught in both mini-residencies and traditional health education settings.
- Increase the racial and ethnic diversity of dental professionals through recruitment, retention, and mentor programs.
- Strengthen public oral health infrastructure to support community -level prevention programs through region-based Division of Public Health dental hygienists.
- Increase the number of oral health professionals and resources in low-income communities through incentive program strategies including: service-learning sites, loan repayment, low-interest loans for infrastructure, Medical Assistance reimbursement increases, tax credits, more flexible licensure policy to facilitate increased mobility of dentists to the state and reducing the administrative burden of Medical Assistance.

Evaluation and Measurement

Multiple resources are available to evaluate and measure progress toward achieving the goals of this objective. These include:

- Wisconsin Youth Oral Health Data Collection Plan
- Family Health Survey
- “Make Your Smile Count” Survey
- Wisconsin Community Water Fluoridation Census
- Medical Assistance dental utilization reports
- Oral Health America Scorecard
- Department of Health and Family Services Oral Health Scorecard
- National Oral Health Surveillance System

Crosswalk to Other Health and System Priorities in Healthiest Wisconsin 2010

Access to Primary and Preventive Health Services: Increase the public health system capacity to assure population access to preventive health services.

Access to Primary and Preventive Health Services: Reduce the proportion of the population that reports difficulties, delays, or the inability to receive ongoing primary and preventive health care.

Sufficient and Competent Workforce: Workforce is key to improving access to preventive and restorative dental care due to issues of maldistribution, licensure, and delegation of duties.

Significant Linkages to Wisconsin’s 12 Essential Public Health Services

This objective and related outputs address many of the 12 essential services.

Monitor health status to identify community health problems: Implement Wisconsin Youth Data Collection Plan, add additional questions regarding oral health to the Wisconsin Family Health Survey,

participate in Oral Health America National Scorecard, and participate in National Oral Health Surveillance System.

Educate the public about current and emerging health issues: Significant in this area is the need to educate the public and policy makers regarding the access to oral health care crisis in Wisconsin. Emerging health issues include the use of fluoride varnishes and the prevention of early childhood caries. It is necessary to expand the use of evidence-based outreach and education programs to underserved groups.

Promote community partnerships to identify and solve health problems: Most of the inputs for this objective require significant collaborations and partnerships. These collaborations can build on the successful “Healthy Smiles for Wisconsin” coalition.

Create policies and plans that support individual and community health efforts: Regulatory authorizations are necessary to allow implementation of new and innovative care models using dental hygienists, assistants and other health professionals. More flexible dental licensure policies are necessary to encourage additional dentists to practice in the state. Selected oral health prevention services need to be included as Medical Assistance billable services for primary care providers within their scope of practice.

Link people to needed health services: This links to the establishment of oral health start-up/expansion grants to increase capacity (facilities, equipment, and providers) of community and school-based clinics.

Assure a diverse, adequate, and competent workforce to support the public health system: This links to the development of a core preventive oral health curriculum for primary health professionals to include competencies in infant oral care, management of high-risk children, and oral health assessments by primary care providers. More flexible dental licensure policies are necessary to encourage additional dentists to practice in the state. Graduates from dental and dental hygiene training programs will more closely reflect the cultural diversity of the state population.

Assure access to primary health care for all: This links to the establishment of oral health start-up/expansion grants to increase the capacity (facilities, equipment, and providers) of community and school-based clinics.

Connection to the Three Overarching Goals of Healthiest Wisconsin 2010

This objective and outputs (activities) have strong connections to all of the Turning Point goals.

Protect and promote the health of all: The outputs focus on increasing access to preventive and restorative oral health care for the population as a whole and for subpopulations that are at high risk for oral diseases.

Eliminate health disparities: The outputs include public education and outreach, service delivery, and workforce activities that are targeted to subpopulations that currently have disparities in disease prevalence and access to oral health care (e.g., lower socioeconomic populations).

Transform Wisconsin's public health system: The objective and outputs address the role of the consumer, delivery system and health care providers, health professions training programs, and policy makers.

Key Interventions and/or Strategies Planned:

- Establish oral health start-up grants to increase the capacity of community and school-based clinics to serve high-risk populations.
- Implement new and innovative care models using dental hygienists, assistants, and other health professionals.
- Increase dental Medical Assistance reimbursement rates.
- Implement a more flexible dental licensure policy.
- Expand the utilization of oral health providers to increase access (e.g., expand dental hygienist scope of practice, expand delegation of care, use of retired providers).

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